Futures Care Management System Design

STEERING COMMITTEE

Next Meeting of Care Management Steering Committee

August 19th, from 9:00 to 11:00 a.m., at 9 Heaton Street, Montpelier, in the CRT offices of Washington County Mental Health Services.

July 15, 2008

2:00 – 4:00 p.m.

108 Cherry Street, Conference Room 3B, Burlington

Minutes

Steering Committee
Peter Albert, Jeff McKee, David Long, Bob Pierattini, Stuart Graves, Nick Emlen, Bill McMains, Tom Simpatico, Marlys Waller, Marie Bean, Cynthia Ward, Jean New, David Gallagher, Harvey Peck, Sheryl Bellman, Victor Martini, Richard Lanza

DMH Staff
Michael Hartman, Beth Tanzman, Judy Rosenstreich, Frank Reed, Dawn Philibert, Michelle Lavallee, Paul Dragon, Staci Pearo

New England Partners
Ron Deprez, Gail Hanson-Mayer, Michael Krupa, John Gale, Janet Bramley

Agenda

- orientation to care management system design
- introduction of New England Partners consulting team
- expectations of project outcomes
- project work plan
- next meeting

Beth Tanzman outlined the need to define operational relationships among the programs in Vermont's network of inpatient, residential, and crisis stabilization beds. She distributed copies of the care management principles framework that was developed by the earlier care management work group over several months and finalized in 2006. The consultants will help us to move forward from these principles to operating protocols.

The Consultants introduced themselves. In addition to the team who joined us today, Ken Minkoff and Christie Kline, the two consulting psychiatrists for Health Partners New England (HPNE), also will be here in Vermont to meet with groups across our system of care. Gail Hanson-Mayer, an advanced practice nurse who spent the first 20 years of her career on the front lines, including state hospitals, will be among the most visible, meeting with folks and visiting programs. Michael Krupa, clinical psychologist and founder / president of HPNE, commented on the challenge of managing a statewide network of programs that are run by agencies with different backgrounds and cultures. Janet Bramley, to us due to her work in integrating treatment for people with co-occurring mental health and substance abuse issues, brings a clinical and research background to the project. John Gale has expertise in behavioral health, critical access hospitals, and managing psychiatric hospital groups in rural states. Edie Barrett of HPNE, not here today, is experienced with Joint Commission hospital accreditation work. Ron Deprez, executive director, Center for Health Policy, Planning and Research, and an epidemiologist by training, has a background in chronic care and efforts to evaluate health care reform initiatives. Ron will coordinate work of the consulting team.

<u>Expectations of Project Outcomes</u>

All in attendance shared what they expected would result from this process and what a care management system design means.

- governance – is it possible to have a self-governing system of care management?
- clients will flow through the system equitably
- resources are available to people when they are needed. Resources are coordinated, especially with the new programs created under Futures
- principles of care management developed earlier need to be carried through to operating protocols, stay true to the principles
- balance a system grounded in data and a system that is friendly to consumers, clinicians, and shared by everybody
- improve consumer care and outcomes in a system with multiple providers
- balance administrative, fiscal and system needs without compromising the clinical
- how the tracks are laid out and trains get there on time
- derive operational plans from our earlier conceptual discussions

- look for more ways that public and private resources can work together
- achieve greater access to the appropriate levels of care for consumers and, along with that opportunity, avoid barriers in access to care
- put principles of care management into practice
- respond faster and more effectively to access appropriate level of care, thus advancing the process of recovery and resiliency
- include people with developmental disabilities who also have mental health issues
- people in crisis can access care in 2 hours, and once the situation is no longer acute, people will have ongoing care as soon as possible
- integration of system resources to best serve clients
- start from the principles we all worked on together and make them operational in a way that people feel heard
- although any program can refuse an admission that they cannot safely treat, that the system as a whole has responsibility for assuring an appropriate treatment option, not just the referring program.

Project Work Plan

As an introduction to discussion of the tasks to be performed, Beth described two different ways to think about how a care management system may be designed. One picture is that of *central management* similar to an air traffic control system. The other is more like *traffic rules* in a city where the meaning of green, yellow, and red traffic signals are understood and followed, allowing the flow of traffic to be largely self-governing. As we engage in discussion and planning about how to organize a care management system, we will see parallels between the flow of traffic and the flow of clients through a system of care in which programs, levels of care, and admission, length-of-stay, and discharge criteria are defined.

Initial questions spoke to the regional differences among programs and their complex variables. Is the goal of care management to pool resources? Remedy a problem? Achieve consistency? As the scope of work initially detailed in the request for proposals, the care management design work would address all three of these goals.

Beth referred to Attachment A, the scope of work section of the consulting team's agreement with DMH, handed out at the meeting. Tasks include development of program descriptions for the various levels of care, which will help to create more standardization of program roles in order to facilitate client access to needed levels of care statewide. All of the work around these issues will be developed in collaboration with the providers who currently offer these services.

Our approach to the work is for a multi-stakeholder group representing multiple perspectives to work throughout the process, meeting monthly with consulting team, New England Partners. There also will be special meetings with

residential, inpatient, emergency, and crisis bed providers in addition to consumers and family members. The consulting team also will meet with the Transformation Council and the Adult Mental Health Program Standing Committee.

There was broad agreement that the system, with all its strengths, has needs at least some of which could be addressed in the design of a care management system. By identifying these needs, the group hoped to focus attention of the consulting team on specific issues.

1. communication among providers in various areas

2. communication barriers (e.g., deaf and hard of hearing in the ER) impair access

3. reduce time screeners spend finding bed / care

4. system knowledge about where people are in the system

5. no place for people to go: discharge resources / options
6. financing / funding

7. lack of continuity of staff

8. stigma / respect

9. access problems created by refusals of care

10. conflict between systems → resolution (lack of match between admission and discharge criteria may need conflict resolution. How do we uniformly describe clinical needs and program resources? Shared risk.)

11. disrupted relationships (between consumers and providers)

12. no coverage or spotty, particularly for psychiatry

13. lack of uniform or honest clinical descriptions

14. dealing with consumer's capacity to seek or refuse treatment

15. access to psychiatry in ER

16. managing when the beds are all full beds

17. assessments need to line up

18. timely interventions

19. uneven distribution of resources (How can a care management system help us achieve a better balance of resources?)
20. increased pressures through managed care to reduce hospitalization (Role of that level of care—inpatient—is sometimes undervalued.)

To the helpful metaphor, comparing a care management system to traffic rules or rules of the road, a comparison to living organisms was suggested. As a single-cell organism grows complex, there is a need to create a central nervous system. That is where we are today in the mental health system of care that has evolved.

The consulting team was asked to present to the Care Management Steering Committee, early in the process, with models and tools out there that could be developed in concert with devising our own care management system.

Responding to the list of what needs attention, Michael Hartman questioned how much is broken and how much is connection? Do we have some crevices that we should address, which may require resources? The rest is probably more a matter of communication. Where are we doing things better than we thought?

Consulting Team Response

Ron Deprez discussed the work he and his team are beginning, stating that the work has to be accessible to everybody. A good gap analysis will help us to prioritize what we want to fix. All on the team will become familiar with system resources, develop understanding of the flow, and meet with various groups, including emergency services directors, CRT directors, hospitals, the DMH Acute Care Team, consumer groups, family groups, and other stakeholders.

Michael Krupa addressed the scope of the project, cautioning on the need to stay focused on the specific tasks outlined in the agreement with DMH or stray too far from these tasks and fail to accomplish the stated goals and objectives.

Ron Deprez emphasized that the project work plan, currently in draft form and distributed today to the Steering Committee, still needs further embellishment and he invited comments on the work plan (to be sent through Judy at DMH).

Communications Plan

Beth stated that Judy Rosenstreich will provide staff support for the care management work, including communications and organizational tasks for

meetings with the consultants, providers, and stakeholder groups. Judy will be the conduit for the information flow from the Steering Committee to consultants.

Judy Rosenstreich 802-652-2023 jrosen@vdh.state.vt.us

She thanked everyone for committing to this process and the good discussion we had today.

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SUBMITTED BY: Judy P. Rosenstreich
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